DOCUMENT RESUME

ED 312 524 CG 022 021

AUTHOR Scottron, Kathleen V.
TITLE Support Group Intervention for Adult Female Rape Victims.
PUB DATE May 85
NOTE 79p.; M.S. Practicum, Nova University.
PUB TYPE Dissertations/Theses - Practicum Papers (043) -- Reports - Descriptive (141) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS *Counseling Services; Females; *Group Counseling; *Intervention; *Program Effectiveness; *Rape; *Social Support Groups

ABSTRACT

Staff of a rape crisis agency recognized the need for counseling services for survivors of sexual assault, but were unable to provide on-going counseling on a regular basis due to a staffing shortage. A support group for adult female rape victims was formed to reduce individual therapists' caseloads, to provide counseling services to a greater number of adult female clients, and to assist the women to regain control of their lives and to recover from their assault experience. The support group combined discussion, role-play, consciousness-raising, assertiveness training, and relaxation exercises to encourage the development of insight, growth, and the remediation of crisis reactions in the participants. The participants (N=8) in the support group completed self-evaluative questionnaires at periodic intervals throughout the 4-month program. Responses to the questionnaires indicated definite reductions in both somatic and psychological distress. These positive changes were attributed to the supportive intervention of the group. The development and implementation of support groups to meet the needs of various types of clients will enable the agency to continue to fulfill its goals and objectives of service and support to those who become the victims of intimate, yet violent, sexual assaults. The appendices include: the number of rapes by jurisdiction, year and month; a 20-item victims questionnaire; exit survey for group members; a needs assessment study of services to rape victims in Florida, 1984; the 1984/85 budget; and relaxation exercises. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED312524

-1042

SUPPORT GROUP INTERVENTION FOR ADULT FEMALE RAPE VICTIMS

BY

KATHLEEN V. SCOTTRON

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Kathleen Scottron

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

SO 022 021

A PRACTICUM REPORT

submitted to the Faculty of the Center for the Advancement of Education of Nova University in partial fulfillment of the requirements for the degree of Master of Science.

May 1985

BEST COPY AVAILABLE

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give this testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my own work, presented here, will earn similar respect.

ABSTRACT

A Support Group Intervention for Adult Female Rape Victims. Scottron, Kathleen V., 1985: Practicum Report, Nova University, Center for the Advancement of Education
Descriptors: Rape/Sexual Assault/Sexual Battery/Crisis Intervention/Rape Trauma Syndrome/Group Therapy/Group Intervention/Group Demographics/Group Confrontation/Group Validation/Group Catharsis/Group Assessment and Formation

A support group developed and led by the author was created to counsel adult female victims of sexual assault. The group was formed to reduce individual therapists caseloads, to provide counseling services to a greater number of adult female clients, and to assist the women to regain control of their lives and recover from their assault experiences.

The support group combined discussion, role-play, consciousness-raising, assertiveness training, and relaxation exercises to encourage the development of insight, growth, and the remediation of crisis reactions in the participants.

The participants in the support group completed self-evaluative questionnaires at periodic intervals throughout the four month program. Responses to the questionnaires indicated definite reductions in both somatic and psychological distress. These positive changes were attributed to the supportive intervention of the group.

TABLE OF CONTENTS

TITLE PAGE		i
AUTHORSHIP STATEMENT		ii
ABSTRACT AND INDEX		iii
TABLE OF CONTENTS		iv
OBSERVER'S VERIFICATION		v
CHAPTER		
I	PURPOSE	1
II	RESEARCH	4
III	METHOD	9
IV	RESULTS	19
V	RECOMMENDATIONS	24
REFERENCE LIST		26
BIBLIOGRAPHY		27
APPENDICES		
APPENDIX A: Agency Statistics 1983-1984		28
APPENDIX B: 20 Item Questionnaire		38
APPENDIX C: Exit Survey for Group Members		40
APPENDIX D: A Needs Assessment		45
APPENDIX E: Agency Budget for Fiscal Year 84-85		56
APPENDIX F: Relaxation Exercises		57
APPENDIX G: Sexual Assault Booklet		64

APPENDIX F

NOVA UNIVERSITY
CENTER FOR THE ADVANCEMENT OF EDUCATION
3301 College Avenue
Fort Lauderdale, FL 33314

OBSERVER VERIFICATION FORM

Verification of Practicum Activity

Dear Observer:

Practicum students in Nova's M.S. and Ed.S. programs are asked to provide external verification that the project activities reported in their final practicum documents took place as described. You have been designated an observer to fulfill this confirmation function by the student named below. On this sheet, then, please write a note attesting to your knowledge of the project activity described in the final practicum report to which this will be attached. (Note that you are not asked to evaluate, or make judgments about the quality of the project.)

The activities described in this report were performed by Ms. Scottron at this facility. The statistical information was compiled by Ms. Scottron, using the records maintained normally by this Agency. The questionnaires used in this project were the work of Ms. Scottron.

Practicum Title Support Group
Intervention with Adult Female Rape Victims

Student's Name Kathleen V. Scottron

Program Site Ft. Lauderdale **Date** May 10, 1985

Observer's Name Joanne G. Richter Joanne G. Richter
(please print ----------and sign)

Observer's position Director, Sexual Assault Treatment Center

I. PURPOSE

The Rape Crisis Center is a 24 hour, seven day week facility which began operation in August, 1977. Operating as a special office of the Public Health and Safety Department, the Agency was established to provide comprehensive and coordinated medical, legal, psychological and educational services. Referrals and requests for services are received on a regular basis from The Department of Health and Rehabilitative Services, The Child Protection Team, The State Attorney's Office, district hospitals, police departments, private physicians and attorneys, and individuals seeking intervention in the traumatic aftermath of a sexual assault.

Program priorities addressed by the Agency were in four areas: (1) psychological; (2) medical; (3) legal; and, (4) educational. Services provided to the public were as follows: (1) crisis intervention and counseling for anyone affected by an alleged sexual assault; (2) initial medical examinations for the collection of physical evidence and follow-up examinations for venereal disease testing; (3) advocacy and support throughout any criminal justice proceedings; and, (4) training and educational programs for private groups, civic organizations, private and public schools, health care personnel in local hospitals, media representatives and law enforcement personnel.

Over the past several years, the Agency has shifted program emphasis from short-term crisis counseling to long-term counseling for victims of sexual assault as well as their families.

In August of 1984, the Agency joined forces with The Department of

of Health and Rehabilitative Services and The Child Protection Team for the sole purpose of coordinating referrals and intakes on charges of sexual assaults perpetrated upon children. At that time, it became the responsibility of the crisis counselors to participate in the clinical interviews of all children who were thought to have been victims of sexual abuse, and the interviews of their primary care-givers. These intakes were scheduled on a daily basis, beginning in the morning and concluding in the afternoon with physical examinations of the alleged victims by an Agency pediatrician. While this system primarily prevented workers from having to subject young children to numerous question-and-answer periods, it also created hundreds of new cases that had to be assigned to caseworkers within this Agency for follow-up counseling. At the same time, the Agency suffered the loss of several caseworkers. It soon became apparent that these two internal situations severely afftected the ability of the remaining staff members to provide counseling services for the Agency's continually increasing client population.

Just as the number of cases involving children continued to expand, so did adult referrals and requests for services (Appendix A). The adult population served by the Agency had not lost the need for counseling services, but the availability of these services was rapidly becoming limited.

As noted in Burgess and Holstrom (1979), counseling services for survivors of sexual assault has undeniable value if it is begun as soon as possible after the crisis is experienced. However, due to the critical staffing shortage and the growing demand for services, this author and her colleagues were prevented from scheduling clients for on-going counseling on a regular basis.

Clearly, there existed a need for the development of a solution to this crisis. The adult clients who were seeking intervention and support following the experience of being sexually assaulted needed to have guidance, reassurance and information available to them as they progressed through the two phases of the rape trauma syndrome, as described by Burgess and Holstrom (1979). These phases, the immediate and the reorganizational, were the periods during which the survivors attempted to reduce their emotional and physical reactions to the assault and regain a sense of control of their lives.

This author suggested the formation of a support group for adult female rape victims, to alleviate some of the scheduling difficulties and incorporate counseling time for several clients into one 2-hour session per week. The goals of the support group were to enhance crisis resolution in the group participants by the use of cognitive and behavioral techniques, and to increase awareness and insight of the members' perceptions of self and environment, thereby reducing their feelings of guilt, helplessness, depression and self-anger, as reported in Sutherland and Scherl (1983).

II. RESEARCH

The research which led to the choice of a support group for rape victims was based on the determination of the need for such a program. According to information presented in a 1984 Needs Assessment Study of the services which are presently available to rape victims in Florida, there was recognized a definite need for the expansion of such services, primarily due to the increase of violent crimes against persons in our society (Appendix D). Additionally, the statistics noted in Appendix A demonstrated a disturbing increase in the number of sexual assaults committed in this County and referred to this Agency for treatment.

Common strategies that have been utilized by other communities to provide services to victims of sexual assault were discussed throughout the available literature. State by state, the programs all differed in the scope of their services, funding sources and target populations, but all persistently acknowledged as their primary objective the reduction of the victim's psychological trauma and the desire to provide a supportive advocacy of her needs as she encountered the medicolegal system of her community. In rape crisis centers throughout the country, individual counseling, peer counseling and support group services were all implemented with consistent success (Sprei and Goodwin, 1983). There did not appear to be a singular approach that was considered to be more effective than others within any particular program, rather, each agency developed its guidelines and services based on client needs, budgetary allowances and program philosophies.

Two facets that presented administrative problems in every program studied were, as with this Agency, funding and staffing. Because the budget for this Agency was controlled through the Board of County

Commissioners, it had recently received additional monies to expand its services. However, even with an increased budget, this Agency continued to experience serious staffing shortages, and became overwhelmed by the demand for services.

The concept of group work, applied in this situation, created counseling services for several clients simultaneously, and expanded some of the services the Agency offered without first having to secure and train additional personnel. Although new staff members were eventually employed, the Agency needed an immediate solution to the problem of overburdened caseworkers. One solution was to limit the length of time during which follow-up services were offered. While this would have been effective in reducing the actual number of sessions the clients participated in, it did not guarantee that they would have regained sufficient control of their lives and resolved any of the psychological and emotional issues which surrounded the trauma of sexual assault. Therefore, because this approach did not represent acceptable standards of clinical practice, it was rejected as a solution to this problem. Another strategy employed to reduce caseloads to manageable levels was to refer a majority of clients to private counseling agencies. This could only be effective if there were counseling services within the community that employed professionals who were familiar and comfortable with the complex reactions to a sexual assault which frequently were manifested by a great many victims. Additionally, it should be noted that private sector counseling agencies did not, nor should they have been expected to, operate on a "no-fee" basis; therefore, many victims who were unable to afford private counseling, and who did not have medical insurance with which to offset the cost of such counseling, were forced to do without. For these reasons, it was obvious that referral to the private sector would have been beneficial to only a select number of persons.

Theoretically then, the most appropriate solution for this Agency

was to offer group services to rape victims. A support group enabled one therapist to work simultaneously with several individuals, all of whom were in different stages of recovery from their assault experiences. Because the basic issues surrounding sexual assault were the expression of power and aggression through a sexual means, the facilitator had to be well-trained in group dynamics and well-versed in feminist theory, consciousness-raising, assertiveness training and humanistic psychology (Sprei and Goodwin, 1983).

As stated in Gallese and Treuting (1981), group work has been noted to be highly applicable and accepted as a form of intervention for crisis resolution. Four primary purposes existed for the formation of group programs. Garvin (1981), described these as: (1) education; (2) growth; (3) remediation; and, (4) socialization. Support, mutual aid, ventilation, validation and identification with others were basic properties of all treatment groups and, therefore, were not identified as separate and distinct purposes in the literature.

According to Yalom (1975), there were innumerable variations of treatment groups that combined the four primary purposes. However, for this support group of adult rape victims, the most effective and appropriate combination of purposes was growth and remediation. Primarily, the combination of these two purposes permitted the development of the members' awareness and insight, through discussion and growth-producing techniques, while at the same time, their coping strategies and problem-solving skills were increased through behavioral interventions. The group focused on the members' problems in dealing with the aftermath of the rape and the way it had created upheaval in their lives. Because the group was composed only of their peers and a skilled therapist, members had the opportunities to discuss and share their feelings freely, lending support to each other. The common bond of sexual assault quickly fostered self-disclosure and

cohesion, as the members learned how the others in the group were dealing with their individual crises.

Two very important factors which had to be taken into consideration when the group program was proposed were time and material costs. The effort and time involved for this author to develop the assessment and formation process, select and approach potential members, and conduct the actual meetings was lengthy and tedious. However, when the value of the group process for the clients and for the Agency was considered, the tedium of the entire process was significantly reduced.

Material costs included the following areas: (1) salary for this author, who acted as the group facilitator; (2) operating expenses for the building where the group meetings were held, which was also the Agency's offices; (3) supplies used to disseminate information about the group; and, (4) the cost of research materials and consultation fees for professional referral services outside the Agency. These expenses were contained within the Agency's normal operating budget (Appendix E).

The final area of consideration in the development of the practicum research involved the relationship between the State Attorney's Office and this Agency. From a legal standpoint, the entire staff of this Agency had always maintained an excellent working relationship with all personnel in the State Attorney's Office and the County's 28 police departments. While it had never been required that adult victims of rape report the crime to the police, it was encouraged by local law enforcement agencies, and was recommended by the State Attorney's Office and the staff of this Agency. Support from those group members who chose to prosecute their assailants was beneficial to others who had not yet begun the legal process, and it was also helpful to those women who decided not to press charges. The decision not to follow through with prosecution often weighed heavily on a woman's mind.

This decision was frequently a major factor in the victim's ability to cope with her reactions and the reactions of her family and friends to the assault.

Many survivors, as noted by Burgess and Holstrom (1979), felt as though they had been victimized not only by the rapist, but by the legal process as well. Aspects involved in the court system supported this belief, as witnessed by continual delays in trials and the fact that a trial, if one occurred, took place in a public setting. Hence, the victim, who repeatedly had to recall and reveal in minute detail all aspects of the assault, once again was forced to live through the experience. The only difference in the ordeal was that a public setting allowed curious courtroom spectators to vicariously witness the assault the second time around. The on-going process of the support group helped to alleviate some of the victim's attendant anxieties as she endured the stress of public exposure and private anguish (Gallese and Treuting, 1981).

III. METHOD

The support group began on January 7, 1985, with ten participants, all of whom had been sexually assaulted within the past year. Members were culled from this author's caseload and from the caseloads of her colleagues within this Agency. There was no immediate response to the letters that had been sent to other social service agencies within the County, explaining the group experiment, but if clients had been referred to the group from those sources, they would have been included without difficulty.

Prior to the first meeting, pre-group interviews were scheduled to assess the members potential to benefit from and contribute to the group process. It was important that members were screened in this manner to avoid including in the group a person who, by virtue of a pre-existing psychiatric history or a history that indicated a need for a more intensive type of treatment, would not be clinically appropriate for a support group setting.

In the pre-group interviews, there were no indications that any of the clients needed referrals to outside treatment providers or continued therapy on a one-to-one basis. The group was led by this author, but external supervision and consultation were provided by a senior colleague within the Agency. Wtih the benefit of this type of non-structured supervision, the clarification of the group's dynamics and the formulation of the group's goals and objectives was accomplished in context with the philosophies of the Agency.

The group sessions were conducted informally, and this author deliberately designed the structure of the meetings to give the members as much control over their group as possible. The leader avoided being excessively controlling or directive, by allowing the

group members to choose the topics for discussion, and letting them decide to what extent they each wanted to participate, either verbally or by their attendance. The two basic guidelines which were expected to be strictly observed were: (1) discussions were to be confined to material which related only to sexual assault or incest; and, (2) all personal communication discussed within the group meetings was not to be shared with any individuals outside of the group.

The support group used various techniques during the sessions to enhance the discussions and to promote the emotional and physical well-being of the participants. Relaxation techniques, such as breath awareness and progressive muscular relaxation were combined with creative visualization procedures, and were used frequently throughout the course of the group project (Appendix F).

By utilizing this type of cognitive and behavioral approach, the members progressed through the reorganization phase to the resolution phase of recovery, and demonstrated a reduction in their physical and emotional distress levels.

In addition to these activities, the leader used role-playing, consciousness-raising, and group assertiveness training to enhance the members' feelings of self-esteem and competency. According to Sprei and Goodwin (1983), such exercises benefit the clients by helping them to realize they are in control of their own recovery.

The group sessions were held once a week, for two hours. The following material describes the discussion topics and the activities which were performed during each session:

Week 1: Introductions were performed and an explanation of the philosophy and purpose of support groups was given. The members were told that the group was essentially theirs to use as they needed, and the self-evaluative questionnaires were explained. The topics for discussion that evening began with several

of the members expressing a desire to create new beginnings for their lives, by their participation in the support group. The subject of the constant upheaval of their lives was discussed quite openly, along with the fact that everyone agreed it helped to be able to talk freely about their feelings and their problems regarding their rapes. The leader emphasized the concepts of support and ventilation, and outlined how important they were to the recovery process. The fact that rape was not merely forced sexual intercourse, but also an expression of violence, anger and aggression was brought up and the members were encouraged to develop positive feelings about their ability to think and react well when faced with a life-threatening situation.

Week 2: The subjects discussed during the second session covered a wide range of psychological responses to the assault. Most of the members indicated that they were having trouble establishing trust and control, and the overall feelings expressed were of increased paranoia and guilt. The feelings of guilt came from the responses of friends and families to the rape, and several of the women acknowledged that they were viewed in some way as having been responsible for the assault. In contrast to these feelings, there was some discussion regarding the desire to survive the violence that had accompanied the assault, and more than half of the members said they were worried that they would never be able to feel safe again. Questions were asked about the length of time the women could expect to feel as though they were riding an "emotional rollercoaster", and it was explained that this was a typical reaction to the trauma of having been sexually assaulted. The women were cautioned that they could expect to feel relatively normal one day, and then could experience anxiety, depression, or anger the next. The leader then introduced the first of the relaxation techniques (Appendix F), and the members then practiced breath awareness exercises which have been designed to reduce stress and promote relaxation by increasing the participants' awareness of both body and mind.

Week 3: This session focused on the fears which were specific to the rape experience. Each member had different things to share, but they all had faced the threat of loss of life at the hands of an angry. violence-prone man. Some of the areas addressed included: (a) the victims' inability to express anger at the rapists, turning their anger instead, towards themselves; (b) the need to survive and submit to the assault, rather than to try to fight off the assailant and risk death; (c) the coping patterns developed for other stressful or frightening situations that were not useful in the assault situation; (d) the need to learn how to deal with their anger in ways that were not harmful to themselves. The leader described the stress-reducing technique of creative visualization, and members participated in this brief exercise. They were asked to close their eyes and to try to picture themselves in a stressful situation, but to stop the picture before the end and then to try to visualize themselves in control of the same situation. The purpose of having the members participate in a creative visualization exercise was to enhance their feelings of self-esteem and competency, and to teach them effective coping skills which could be used in difficult, dangerous, or threatening situations.

Week 4: The fourth session was devoted to discussion and the completion of the first self-evaluative questionnaire (Appendix B). The questionnaire discussed some of the most distressing physical and emotional reactions to sexual assault and requested that the group members rate themselves numerically as to the amount of distress they were currently experiencing. The remainder of the session was spent discussing the various reactions to the aftermath of the rape, and some of the reactions that had been expressed by husbands, boyfriends and parents. Many of these individuals had agreed that the rape itself was traumatic, but they also seemed to feel that the victims could have tried to prevent it in some way. The leader reinforced the life and death aspect of the assault, in which the first priority of the woman was her own survival. It was also mentioned that the sooner the woman became, in the rapist's opinion, degraded, the sooner

the assault was over. Those members who indicated that they had fought back also stated that the violence then escalated in response to this reaction. It was concluded by the group that they could learn to live with having been assaulted, but that they did not have to accept the guilt and the blame that should have been attributed to the rapist. The final topic of discussion for the evening was the confusing social atmosphere regarding how men treat women and how women are taught to respond to men. While no quorum was reached on this particular issue, varying opinions were expressed in a congenial manner.

Week 5: During this session, the members appeared to the leader to be more relaxed and comfortable with each other, and more willing to discuss their differences of opinion. The group also appeared to be very supportive, as a whole, of one member who had chosen to drop out of the support group. Her decision was discussed in light of individual coping styles, and viewed in a positive way. It was emphasized that her need for support might change, and if it should, she could re-join the group at any time. Further discussion centered around the common fear that one incident of victimization could lead to the development of future problems for the members, who might begin to perceive themselves as vulnerable, and therefore, able to be easily victimized. This major concern was clarified by the leader reinforcing the suddenness of the rape situations, and providing a means by which the women could understand the concept of the involuntary loss of control vs. the choice to create a personal safety hazard. From this point, the topic evolved into constructive ways the women could protect themselves at home, on the job, in public places and while driving. A hand-out booklet (Appendix G), was distributed, which outlined in greater detail some of these important strategies for creating personal safety in a wide variety of settings. The meeting ended following a role-play situation in which the leader played a woman who exhibited both safe and unsafe ways of interacting in a potentially dangerous situation.

Week 6: The subject for discussion this evening was the emotional

pain the women experienced when they found themselves to be the victims of society as well as the victims of a rapist. Five of the members had been assaulted by strangers, and three had been raped by men who were known to them. As of the date of this meeting, only one suspect had been arrested, but he was quickly released, without bail, on his own recognizance. The women angrily discussed the prevailing belief that the criminal justice system seemed to be designed to dispense leniency instead of punishment. The leader commented that this view has frequently been expressed by victims of violent crimes, and that it reflects a growing concern of the general public that our laws and courts have not responded well to the needs of victims. It was also mentioned that in the State of Florida, there are mandatory sentencing laws, which aid judges in determining the amount of prison time a convicted rapist must serve. However, in spite of these stringent guidelines, the vast majority of rapists, if tried and convicted, usually are able to plea-bargain their sentences to a lesser charge, which would permit a reduction of the sentence that would be imposed.

The group continued to discuss the problems that they had encountered in the judicial setting, by having been asked to repeat their stories not just once, but many times. The commonly shared feeling was that they were not believed by a large number of people within the criminal justice system whose positions represented authority. This type of discussion seemed to bring out many feelings of anger, which had been unrecognized and unexpressed prior to this meeting.

Week 7: This session began with more relaxation techniques. The members practiced breath awareness and progressive relaxation, to enhance their feelings of control and competency. The discussion then focused on the type of men who are prone to violence and who commit sexual assaults. The leader discussed how pre-conceived

ideas of what constitutes a rape were noted to have been interfering with the womens' understanding of the types of violence that they had been exposed to. The leader outlined the three types of rapists and the group discussed their motivational keys which caused them to rape in order to relieve their aggression and hostility.

Week 8: This session was spent completing the second self-evaluative questionnaire (Appendix B). Again, the group members were asked to rate the amount of distress they were feeling, both physically and emotionally. The leader then introduced another creative visualization exercise, which was designed to increase the feelings of autonomy and control of the members. The group then discussed their views of women, whom they felt have been socialized to be non-aggressive, and they talked about the adjustments they felt they had made thus far in resolving their crisis reactions. Some time was spent discussing the probability of being assaulted again, and the fears that this belief generated in the women were shared.

Week 9: This evening was devoted to talking about the ways in which the police responded when they were called by the women who had been assaulted. There were questions asked about the use of deadly force (e.g.:the use of a weapon, such as a gun); and the use of physical force to defend themselves. The leader explained the reluctance of counselors and law enforcement personnel to recommend the use of deadly force, stressing instead that the best type of defense for a woman appeared to be an awareness of her surroundings and an ability to think and act calmly in a crisis situation. The leader also pointed that the majority of serious injuries inflicted upon women during an assault were the result of the victim's attempted use of physical or deadly force, which further angered her assailant and possibly caused him to retaliate with escalated physical violence.

Week 10: During this meeting, the members centered the discussion on the topic of emotional pain and the ways in which they had learned to deal with it. The group examined their feelings about the length of time it took to resolve their crisis reactions and they also talked about their overwhelming desire to forget about their assaults and get on with their lives. The leader reminded them of the emotional nature of their trauma and compared it to a physical injury. It was pointed out that the healing process was lengthy and often painful, but that they had already made considerable progress and would continue to do so.

Week 11: The topics discussed during this meeting were the members' difficulty in forming trusting relationships with men. There was some concern voiced about being able to trust and wanting to learn to trust, and whether it was possible to learn to control the type and amount of confidence that was needed to take new risks in intimate relationships. The group then talked about the various ways they were using to protect themselves physically, and they expressed relief when they realized they all shared similar concerns. The leader conducted a role-playing exercise, in which two of the members demonstrated some of the skills they had developed to increase their personal safety.

Week 12: This week, the members completed the final self-evaluative questionnaire (Appendix B). They discussed their needs to feel safe, both physically and emotionally, and they seemed to agree that they all felt safer when at home, as opposed to being out in public. One of the group members revealed that she was moving to another state, within a week. The group appeared to be supportive of her decision, although several women commented that they did not feel as though moving away could solve any problems. The leader questioned

if they felt that moving away was parallel to running away, to which some members replied that it did seem as though the two ideas were closely related. However, all the members reported that they felt the individual who was planning to move was in control of her own life, and should do what would help her to feel better.

Week 13: The group began to focus on the goal of termination, and discussed some of the issues that had been resolved and others that still needed to have more time and attention prior to the termination date. Several of the members had cautiously approached a resumption of sexual intercourse and needed much support and encouragement from the leader and the other group members as they talked about their feelings. The problem of experiencing flashbacks appeared to be an issue that needed explanation from the leader. It was stressed that the members needed to be relaxed, both physically and emotionally, before they began to have intercourse with their partners. To facilitate this goal, the leader suggested that they practice their relaxation techniques and exercises before anticipating engaging in sexual contact. Communication patterns between couples were examined, and the leader emphasized how important it was for both persons to be open and honest when discussing their physical and emotional needs and desires.

Week 14: The discussion from the previous week was continued for this meeting. The leader introduced assertiveness as a direct way to communicate with a partner, and the members participated in a role-playing exercise that was designed to demonstrate effective communication between two people. Termination was again discussed, as the members talked about the ways the dissolution of the group would affect them.

Week 15: This group session was used to explore how the women felt about the group and where each person was in relation to her own crisis resolution. Despite the varying responses to questions about their attitudes towards and opinions of the group process, the over-all response was favorable. The remainder of the session was devoted to a discussion of the members' desire to continue the group on a social or possibly therapeutic level.

Week 16: During the final group meeting, the members completed the exit survey (Appendix C). This survey asked for their opinions and particular information regarding the contact they had following their assaults with the police, the judical system, this Agency, and with significant other persons in their lives. The members and the leader then discussed some of the highlights of past sessions and the leader emphasized the importance of the members' contributions and support of each other throughout their recovery process. Before the group concluded this final meeting, the leader then briefly met with each member privately, to reinforce, on a personal level, her ability to continue her own healing process. The members then participated in a final relaxation exercise, to emphasize their feelings of emotional and physical well-being.

IV. RESULTS

The evaluation of this practicum was done by this author and by the group participants. Because this author had numerous opportunities to observe the group members on a regular basis, she recorded, in summary form, the content of the group sessions. These observations then made it possible for her to note what progress was made towards remediation of the members' physical and emotional difficulties, and also enabled her to determine which factors remained problematic for the group members as they attempted to resolve their initial crisis reactions. However, because the structure of the support group was open and informal, it should be noted that member attendance and participation were key factors in the evaluation process.

By permitting flexibility in attendance, the leader allowed the group members to apply their own coping mechanisms to the reality of their assaults. This was necessary to reinforce the womens' feelings of autonomy and control, a strategy which has been suggested by Sprei and Goodwin (1983).

Most definitive as evaluative tools were the responses provided by the members to the subjective questionnaire (Appendix B), and to the exit survey (Appendix C). These were completed at periodic intervals of four, eight, and twelve weeks, and upon termination of the support group. Reduced numerical responses to the 20 Item questionnaire demonstrated the success of the group process and

experience for each member. Based on a continuum scale of 1 to 5, with 1 being equal to little or no distress, and 5 being the equivalent of severe and continued distress; at the 4th week session, the respondents indicated that:

1. Most of the women in the group were not experiencing chronic physical illness or symptomology which required the care of a physician.

2. All of the group members felt that their most distressing psychological reactions to the assault (e.g. fear of death, rejection or other negative responses from family or friends, feelings of guilt or self-blame) had been reduced or resolved to tolerable levels.

When these same group members were asked to rate themselves on an identical scale, four weeks later, they provided the following information:

1. Physical problems such as insomnia, changes in menstrual cycles, or loss of appetite were reported by 3 of the respondents.

2. Psychologically, the group members said that although they felt they were riding an "emotional rollercoaster," they were not experiencing any severe and continued distress.

3. The mood changes which the members had discussed in previous meetings continued to occur sporadically, but there was no indication that they created unmanageable problems for the women.

During the 12th weekly session, the women were asked to rate themselves a final time, using the same subjective items and the

same scoring method. At that time, they responded with the following information:

1. The physical ailments that had earlier been reported were resolved with no residual difficulty.

2. Some of the members had resumed normal sexual relationships and reported that although difficulties were initially encountered, these had subsided and were no longer problematic.

3. The psychological areas that had been stressful and difficult for the women were now reported as being resolved, or significantly reduced.

4. The initial crisis reactions which were discussed throughout the group program had been resolved without long-term impact.

During the final session of the support group, eight members completed the exit survey (Appendix C). The results provided the following information:

1. Following their assault; 5 women made immediate police reports; 1 chose to make a police report after the fact; and 2 decided against initiating any police action.

2. Medical care was requested by 5 women, 4 of whom were treated at the Rape Crisis Center; although one woman was initially taken to a local hospital, she was subsequently referred to the Center for medical treatment.

3. Of the 6 women who notified the police, 5 reported they were treated in a respectful, supportive and professional manner, but 1 woman indicated that the officer (male) who responded to the call appeared to her to be judgemental and rude.

4. Of the 8 women who responded to the questionnaire, only one indicated that her assailant has been arrested.

5. The reactions of the victims' families and friends to the

assault were primarily anger and shock which was directed at the rapist, however, 3 respondents also indicated there was some anger directed towards themselves, by significant others.

6. All the respondents revealed how they had, or knew of, at least one individual who was supportive and helpful and who refrained from expressing negative emotions when informed of the assault.

7. The least helpful and supportive persons were reported by the women to be either boyfriends or parents, however, there was little indication that their non-supportive attitudes were the direct result of the assault situation; rather, it appeared that these attitudes were part of the normal style of communication between the victims and these individuals.

8. Fewer respondents indicated that they would report the assault to the police immediately, if they were assaulted again.

9. One woman was able to press charges against her assailant, but the charge was reduced to one of aggravated assault and the defendant was placed on eight years probation.

10. The services received from the Rape Crisis Center were rated as excellent or good by all the respondents.

11. These services were rated as such due to a perception of helpfulness and support for the victims.

12. One woman reported she had needed and subsequently received services from another social service or mental health agency.

13. There were 4 individuals who contracted venereal diseases as a result of their assaults, which necessitated medical treatment.

14. Two of the members were told about the availability of the support group services as a direct result of their contact with the police, while 6 of the women learned about the group from their exposure to the Center and their contact with a crisis counselor.

15. Participation in the group meetings was noted to have been positive, with 8 members attending most or all of the sessions.

16. The helpfulness of the group meetings was rated as fair to good, by 6 of the 8 members who were regular participants.

17. All of the members indicated that they would recommend the services of the Rape Crisis Center to family or friends, if they were to be assaulted.

18. The reasons most would do so was because of their perception of a positive, supportive, and non-judgemental atmosphere.

It is interesting to note that since the development and implementation of this practicum, six separate groups have been organized by this author's colleagues within the Agency, to expand and enhance the counseling services which are currently being used to serve the public.

V. RECOMMENDATIONS

Based on the group participants' responses to the exit survey (Appendix C), the Agency's Director and Clinical Supervisor agreed with this author that a support group program for adult rape victims in this County was a necessary and vital project that warranted expansion and continuation. This author would like to suggest several appropriate ways in which support groups could benefit both the client population that is served by this Agency, and the caseworkers who work on a daily basis with individuals and families who are in crisis. These suggestions are:

1. That the Agency expand the application of the support group process to include children, adolescents, and adult women who have experienced incest as children.

2. The clinical staff should develop groups for victims of sexual assaults other than rape (e.g.: incest).

3. The Agency utilize the professional services of a consulting clinical psychologist to provide group counseling services for incestuous fathers or stepfathers, who desire to change their aberrant behavior, and who will actively participate in group therapy in order to do so.

4. The Agency should design and provide training for volunteer co-leaders and peer leaders, who would be able to assist the professional staff with these aforementioned group projects.

The formation of these groups will lessen the amount of time that clients normally have to wait for follow-up services, and will reduce the number of clients this author and her colleagues currently see on a one-to-one basis. Realistically, the development and implementation

of support groups to meet the needs of various types of clients will enable this Agency to continue to fulfill its stated goals and objectives of service and support to the citizens of this County who reluctantly become the victims of intimate, yet violent, sexual assaults.

References

Anderson, R.A. (1978). Stress Power. New York: Human Sciences Press.

Burgess, A.W., & Holstrom, L.H. (1979). Rape: Crisis and Recovery. Bowie, M.D: Brady.

Collier, H.V. (1982). Counseling Women: A guide for therapists. New York: Free Press.

Corey, G. (1977). Theory and practice of counseling and psychotherapy. Monterey, CA: Brooks/Cole.

Callese, L.E., & Treuting, E.G. (1981). Help for rape victims through group therapy. American Journal of Nursing, 19 (8), 20-21.

Halpern, S., Hicks, J., & Crenshaw, L. (1978). Rape: Helping the victim. Oradell, N.J: Medical Economics.

Sprei, J., & Goodwin, R.A. (1983). Group treatment of sexual assault survivors. Journal for Specialists in Group Work, March, 1983.

Sutherland, S. & Scherl, D. (1970). Patterns of response among rape victims. American Journal of Orthopsychiatry, 40, 503-511.

Yalom, I.D. (1975). The theory and practice of group psychotherapy. New York: Basic Books.

Bibliography

Aguilera, D.C., & Messick, J.M. (1982). Crisis intervention: Theory and methodology (4th ed.). St. Louis: C.V. Mosby.

Brownmiller, S. (1975). Against our will: Men, women and rape. New York: Simon and Schuster.

Castleman, M. (1980). Sexual solutions: An informative guide. New York: Simon and Schuster.

Garvin, C.D. (1981). Contemporary group work. Englewood Cliffs, N.J: Prentice-Hall.

Levine, B. (1979). Group psychotherapy: Practice and development. Englewood Cliffs, N.J: Prentice-Hall.

Nicholas, M.W. (1984). Change in the context of group therapy. New York: Brunner/Mazel.

Sangiuliano, I. (1980). In her time. New York: Morrow Quill Paperbacks.

Tilley, B.W. (1984). Short term counseling: A psychoanalytic approach. New York: International Universities Press.

APPENDIX A

1983

I. JURISDICTIONS	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
.S.O.	12	8	6	13	14	6	16	11	5	5	9	11	116
Coconut Creek	0	0	1	0	0	0	0	0	0	0	0	0	1
Cooper City	0	0	0	1	1	0	0	0	0	1	0	0	3
Coral Springs	0	1	0	0	1	1	0	1	1	0	0	1	6
Dade County	0	0	0	0	0	0	0	0	0	0	0	0	0
Dania	3	0	2	0	1	1	1	2	2	1	3	1	17
Davie	2	2	0	1	4	1	3	3	0	1	2	1	20
Deerfield Beach	0	1	0	2	0	0	0	1	3	0	0	1	8
Florida Highway Patrol	0	0	0	0	0	0	0	0	0	0	0	0	0
Fort Lauderdale	8	6	10	10	18	12	15	11	9	9	8	16	132
Hacienda Village	0	0	0	0	0	0	0	0	0	0	0	0	0
Hallandale	0	1	3	2	2	0	0	2	2	0	2	2	16
Hollywood	2	5	3	3	5	5	5	6	1	3	5	1	44
Lauderdale-by-the-Sea		0	0	0	0	0	1	0	0	1	0	0	2
Lighthouse Point		0	0	0	0	0	0	0	0	0	0	0	0
Margate		1	0	0	0	0	0	0	1	0	0	0	2
Miramar		2	1	1	1	1	0	0	0	2	1	0	9
North Lauderdale		0	2	0	0	0	0	0	1	0	0	0	3
Oakland Park		0	2	1	0	4	0	2	1	2	3	3	18
Pembroke Pines		1	0	0	1	0	1	0	0	1	2	0	6
Plantation		3	1	0	0	1	2	0	0	1	0	0	9
Pompano Beach	1	1	2	1	4	4	3	0	0	3	1	2	22
Seminole	0	0	0	0	0	0	0	0	0	1	0	0	1
Sunrise	1	0	0	1	0	2	0	1	1	0	0	0	6
Tamarac	0	1	1	2	0	0	0	0	0	0	0	1	5
Weston Manors	1	0	0	1	2	0	0	0	0	0	0	0	4
U.S. Police Report	2	6	5	3	3	4	2	2	0	4	2	3	36
F.H.P. R.S./CPT													
Unknown	1	2	3	0	2	0	4	9	9	1	2	1	34
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520

BEST COPY AVAILABLE

II. LOCATION	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
Victim's Residence	8	8	12	12	16	10	27	9	8	19	12	14	155
Suspect's Residence	6	2	3	6	4	5	4	1	5	1	4	4	45
Abduction Car/Street	4	2	5	5	10	6	6	6	2	0	4	5**	55
Assailant/Victim's Car	4	14	4**	6	10*	6	3	4	4	4	7**	4	70
Field/Woods	1	2	1	6*	8	4	2	1	0	2	4	3*	34
Place of Employment	0	1	1	0	0	2	1	0	0	0	0	0	.5
Beach	0	1	2	0	1	1	0	0	0	0	0	0	5
S.F.S.H.	0	0	2	1	0	0	1	1	0	1	0	0	6
Jail/Detention Ctr.	1	0	1	0	0	1	0	0	1	0	0	1	5
Parking Lot	0	3	0	1	1	0	0	0	0	0	0	1	6
Motel	2	1	1	2	0	1	1	3	1	1	1	4	18
Vacant House	0	2	1	0	2	0	1	1	0	1	1	0	9
Alley	0	0	0	0	0	0	0	0	0	0	0	0	0
School/School Grounds	0	1	0	0	0	0	1	0	0	0	1	1	4
Unknown	8	2	3	0	4	3	5	8	5	6	0	2	45
Other	0	2	6	3	3	3	1	17	10	1	6	6	58
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520

*Hitchhiking prior to assault

SEX	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
Female	30	38	37	41	55	40	53	49	36	33	40	42	492
Male	4	3	5	1	4	2	0	2	0	3	0	2	26
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520
RACE													
White	23	31	33	29	36	32	38	34	25	29	24	35	369
Black	11	9	9	13	21	10	15	17	11	7	16	9	148
Other or Unknown	0	1	0	0	2	0	0	0	0	0	0	0	3
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520
DAY OF WEEK													
Monday	3	3	4	8	5	8	6	6	7	5	1	8	64
Tuesday	1	2	6	4	8	3	3	8	0	2	7	6	50
Wednesday	1	6	5	3	6	8	7	6	1	6	7	5	61
Thursday	7	6	8	5	4	6	7	6	3	3	4	6	65
Friday	2	4	3	4	7	4	7	5	2	2	2	4	46
Saturday	6	11	3	8	12	5	12	10	8	7	10	5	97
Sunday	7	4	5	8	10	5	7	5	6	4	7	8	76
Unknown	7	5	8	2	7	3	4	5	9	7	2	2	61
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520
AGE													
0-11*	10	6	8	5	7	2	11	7	6	7	8	4	81
12-17**	5	8	8	10	16	9	10	11	9	7	6	11	110
18-25	10	14	16	16	23	15	17	18	13	10	15	19	186
26-49	7	12	10	9	13	15	12	13	6	10	9	8	124
50-60	2	1	0	0	0	1	3	2	1	1	1	2	14
Over 60	0	0	0	2	0	0	0	0	1	0	0	0	3
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520

*12 and under Capital Felony **17 and under Juvenile

VII. TIME OF DAY	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
7:00 a.m.- 2:59 p.m.	2	4	4	4	8	2	10	4	1	6	5	4	54
3:00 p.m.-10:59 p.m.	9	9	15	15	19	8	9	6	6	10	9	10	124
11:00 p.m.- 6:59 a.m.	16	18	12	19	25	21	22	23	14	12	19	23	224
Unknown	7	10	11	5	7	11	12	18	15	8	7	7	118
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520
VIII. WEAPON													
Bodily Force	7	2	9	12	17	19	13	17	13	9	10	18	146
Verbal Threats	3	7	6	3	11	2	7	5	5	3	9	1	62
Knife	4	7	3	8	5	2	8	11	4	7	5	10	74
Gun	6	6	5	7	7	6	5	1	3	2	5	5	58
Other	1	4	3	1	5	1	4	0	4	0	1	0	24
None	4	9	7	8	6	9	8	6	1	5	6	8	77
Unknown	9	6	9	3	8	3	8	11	6	10	4	2	79
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520
X. VICTIM/OFFENDER RACIAL COMPARISON													
White/White	14	26	19	13	24	18	25	19	8	22	13	21	222
White/Black	4	3	10	12	7	12	6	7	9	3	6	10	89
Black/Black	10	7	7	13	19	5	14	14	8	6	14	7	124
Black/White	0	1	0	0	1	1	0	2	1	0	1	2	9
Unknown	6	3	5	0	5	1	5	7	6	3	3	4	48
Other	0	1	1	4	3	5	3	2	4	2	3	0	28
TOTAL	34	41	42	42	59	42	53	51	36	36	40	44	520

XI SUMMARY	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL	TOTAL%	
Reported to S.A.T.C.	34	41	42	42	59	42	53	51	36	36	40	44	520		
Victim Signed Waiver															
No Police Report	2	6	5	3	3	4	4	2	0	4	2	3	38		
Incest	6	4	4	1	3	1	2		0	5	1	4	31		
Case Filed With the State Attorney's Office															
Injuries	9	22	6	15	22	10	17		16	12	14	16	166		
CPT-HRS Pediatric Exams															
TOTAL															
% TOTAL															

1984

JURISDICTIONS	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL	
S.O.	10	3	7	11	5	9	7	21	12	9	15	5	114	
conut Creek	0	0	0	0	1	0	0	0	0	2	0	0	3	
oper City	0	0	0	0	0	0	0	0	0	0	0	0	0	
ral Springs	1	0	0	0	0	0	0	1	0	0	4	1	7	
de County	0	0	0	0	0	0	0	1	0	0	0	0	1	
ale	0	0	1	0	3	2	0	1	1	3	0	3	14	
vie	0	1	1	1	1	1	3	0	2	1	0	1	12	
erfield Beach	2	2	3	0	1	0	2	0	1	1	1	3	16	
rida Highway Patrol	0	0	0	0	0	0	0	0	0	0	0	0	0	
rt Lauderdale	8	12	11	9	10	9	15	15	15	7	10	12	133	
lenda Village	0	0	0	0	0	0	0	0	0	0	0	0	0	
ndale	0	1	0	0	1	1	1	5	1	2	2	2	16	
llywood	3	1	7	2	2	6	5	8	9	5	5	5	58	
derdale-by-the-Sea	0	0	0	0	1	0	1	0	0	0	0	0	2	
thouse Point	0	0	0	0	0	0	1	0	0	1	1	0	3	
gate	0	0	1	1	0	0	0	2	2	5	4	1	16	
mar	0	1	1	0	0	1	0	1	0	2	0	3	9	
rth Lauderdale	1	1	0	0	0	0	0	1	1	0	0	0	3	
kland Park	2	1	2	0	2	0	1	3	3	1	2	2	19	
broke Pines	0	1	0	0	1	0	0	0	1	0	0	0	3	
tation	1	0	0	0	0	2	0	2	3	2	2	0	12	
mpano Beach	1	3	10	3	6	4	2	11	7	7	5	7	66	
minole	0	1	0	0	0	0	0	1	0	0	0	2	4	
rise	0	0	1	0	0	0	0	0	0	2	1	0	4	
marac	2	0	1	0	0	0	0	1	0	0	0	0	4	
ton Manors	0	0	1	0	0	0	1	1	0	3	0	1	7	
Police Report	2	2	5	7	2	1	0	7	15	22	2	8	73	
R.S./CPT													****17	****See Summary Sheet
known	0	0	0	0	1	2	8	8	16	0	29	7	71	
OTAL	33	31	52	34	37	38	47	105	89	75	83	63	687	

44

45

BEST COPY AVAILABLE

LOCATION	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
Victim's Residence	8	11	10	12	15*	10	14	23	10	10	9	12	144
Suspect's Residence	4	2	8	3	0	5	9	12	7	3	6	5	64
Abduction Car/Street	7	4	3	3	1	4	6	6	7	2	2	4	49
Assailant/Victim's Car	5	5	9*	****7	***6	3	1	2	2	5	2	7	54
Field/Woods	2	0	0	0	5	0	2	3	4	5	2	3	26
Place of Employment	0	0	0	0	1	0	0	0	0	0	0	0	1
Beach	1	0	1	1	0	0	0	1	1	0	0	0	5
S.F.S.H.	0	0	2	0	0	0	0	0	2	0	1	0	5
Jail/Detention Ctr.	1	0	2	1	0	1	0	1	0	0	0	0	4
Parking Lot	0	0	1	0	0	0	0	2	0	0	0	1	3
Motel	0	1	1	2	1	1	0	1	1	2	1	2	14
Vacant House	1	0	2	0	0	0	0	0	0	1	0	0	4
Alley	0	0	0	0	0	0	0	0	1	0	0	1	2
School/School Grounds	1	1	0	0	1	0	0	3	0	1	1	1	9
Unknown	1	2	7	3	6	2	9	46	53	43	43	23	238
Other	2	5	8	2	1	12	6	5	1	3	16	4	65
TOTAL	33	31	52	34	37	38	47	105	89	75	83	63	687

*Hitchhiking prior to assault

III. SEX	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
Female	31	30	47	3	36	34	42	94	69	66	77	59	588
Male	2	1	5	31	1	4	5	11	20	9	6	4	99
TOTAL	33	31	52	34	37	38	47	105	89	75	83	63	687
IV. RACE													
White	22	21	39	25	20	30	25	62	45	58	50	39	436
Black	11	9	12	9	16	7	20	35	30	17	25	23	214
Other or Unknown	33	31	52	34	37	38	47	105	89	75	83	63	687
TOTAL													
V. DAY OF WEEK													
Monday	4	5	6	11	6	0	6	7	3	6	4	2	60
Tuesday	2	3	2	4	4	7	2	9	2	3	2	2	42
Wednesday	6	4	6	2	7	6	6	9	1	5	2	8	62
Thursday	5	6	2	2	5	5	9	7	3	5	5	8	62
Friday	7	2	6	3	3	3	4	4	6	5	4	5	52
Saturday	4	6	14	3	7	9	7	8	6	8	3	6	81
Sunday	2	2	8	5	3	2	6	2	4	5	6	6	51
Unknown	3	3	8	4	2	6	7	59	64	39	37	26	277
TOTAL	33	31	52	34	37	38	47	105	89	75	83	63	687
VI. AGE													
0-11*	3	7	11	7	7	3	12	61	55	31	48	26	271
12-17**	9	8	12	12	2	9	4	21	10	16	12	7	122
18-25	15	11	18	9	11	14	12	10	12	17	13	18	160
26-49	6	5	9	5	17	9	14	9	7	10	9	11	111
50-60	0	0	1	1	0	0	0	3	1	0	0	0	6
Over 60	0	0	1	0	0	2	0	1	4	1	1	1	11
TOTAL Unknown	0 33	0 31	0 52	0 34	0 37	1 38	3 47	0 105	0 89	0 75	0 83	0 63	6 687

*11 and under Capital Felony **17 and under Juvenile

VII. TIME OF DAY	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
7:00 a.m.- 2:59 p.m.	4	7	8	3	3	0	2	5	1	4	1	2	40
3:00 p.m.-10:59 p.m.	9	6	14	5	11	10	9	5	9	7	6	8	99
11:00 p.m.- 6:59 a.m.	15	11	18	18	17	15	17	20	12	20	12	24	199
Unknown	5	7	12	8	6	13	19	75	67	44	64	29	349
TOTAL	33	31	52	34	37	38	47	105	89	75	83	63	687
VIII. WEAPON													
Bodily Force	4	8	13	9	6	10	7	9	6	10	5	8	95
Verbal Threats	7	1	10	2	6	5	9	6	5	7	2	6	66
Knife	7	4	7	4	4	8	9	4	3	7	4	7	68
Gun	5	5	2	3	8	4	4	1	3	3	3	11	52
Other	1	3	2	1	0	1	1	2	1	0	3	3	18
None	5	8	9	5	10	5	1	8	4	6	4	4	69
Unknown	4	2	9	10	3	5	16	75	68	42	62	24	319
TOTAL	33	31	52	34	37	38	47	105	89	75	83	63	687
X. VICTIM/OFFENDER RACIAL COMPARISON													
White/White	16	17	25	15	12	19	12	35	7	28	8	24	218
White/Black	5	2	11	5	5	5	7	3	8	7	1	7	66
Black/Black	7	9	12	9	15	8	17	19	8	10	12	18	142
Black/White	4	0	0	0	1	0	0	1	0	0	0	0	6
Unknown	1	1	4	3	3	4	8	42	68	30	61	14	239
Other	0	2	0	2	1	2	3	5	0	0	1	0	16
TOTAL	33	31	52	34	37	38	47	105	89	75	83	63	687

XI SUMMARY	JAN.	FEB.	MARCH	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL	TOTAL%
Reported to S.A.T.C.	33	31	52	34	37	38	47	105*	89*	75*	83*	63	687	
Victim Signed Waiver														
No Police Report	2	2	5	7	2	1	0	17	15	22	2	8	73	
Incest	2	4	2	0	1	1	2	12	13	18	19	17	91	
Case Filed With the State Attorney's Office														
Injuries	10	11	13	7	12	13	14	16	13	11	11	15	146	
CPT-HRS Podiatric Exams	0	0	0	0	0	0	0	75	59	42	50	23	***249	
TOTAL														
% TOTAL														

** Beginning in August, the total number of cases reported to SATC will include those intakes and exams done at the request of CPT, HRS, SAO, and law enforcement on Child Victims. Unusually high total numbers indicate exams done on alleged victims and siblings.

Appendix B :20 Item Questionnaire

The items listed below are descriptive of some distressing physical symptoms and emotions rape victims have reported experiencing after their assault. For each item, please indicate how much distress or discomfort you may have felt by placing a number beside each one as follows:

1- rarely or none of the time
2- a little of the time
3- some of the time
4- a good part of the time
5- most or all of the time

1. Sometimes I am bothered by vague pains or aches in various parts of my body. _____

2. Sometimes I have trouble falling asleep or staying asleep at night. _____

3. Sometimes I feel as though my emotions are riding a rollercoaster. _____

4. Sometimes I find myself feeling very disoriented under pressure, and I "blow up" over minor problems. _____

5. Sometimes just thinking about the assault can make me feel nauseous or cause me to lose my appetite. _____

6. Sometimes I feel that I worry too much. _____

7. Sometimes it seems as though my family or friends don't want to listen when I want to talk about the assault. _____

8. Sometimes I feel as though I am "caged in" and just really need to get away. _____

9. Sometimes I wonder if I will ever be able to trust a man again. _____

10. Since the assault, sometimes I purposely limit my daily routine, to doing just the things I must, like going to and from work, grocery shopping, etc. _____

Appendix B: 20 Item Questionnaire

1- rarely or none of the time
2- a little of the time
3- some of the time
4- a good part of the time
5- most or all of the time

11. Sometimes I find myself bored or easily distracted when doing something I used to find enjoyable. _____

12. Sometimes I worry that I may be drinking or smoking more than I used to. _____

13. Sometimes I seem to tire very easily and want to sleep a whole day away. _____

14. Sometimes I feel guilty, as though I should have done something more to prevent the rape. _____

15. Sometimes I seriously consider moving away, because a fresh start may help me to forget the assault. _____

16. Sometimes I find myself worrying that I'll never be able to have a healthy sexual relationship. _____

17. Sometimes I experience unusual changes in my menstrual cycle. _____

18. Sometimes I worry that my assailant will come back and rape me again. _____

19. Sometimes I find myself in tears, for no apparent reason. _____

20. Sometimes I feel very angry and would like to be able to have revenge on my assailant. _____

Appendix C: Exit Survey for Group Members

The purpose of this project has been to determine what needs rape victims have, and whether the existing services in this County meet those needs. We do not want to know the details of your assault, but rather, your reactions, problems and ways of coping afterwards. We also want to know if participating in this support group has been helpful to you. Your responses will be treated confidentially. Please indicate your age and the first initial of your first name in the upper right hand corner. Take as much time as you need to answer this form and then place it in the envelope provided. Thank you.

1. After your assault, what happened in the next few hours? Did you get medical attention? Did you call the police?

2. If you received medical attention, how did this take place? Where did you go, were you helped immediately, what were your reactions to the medical care? Why did you choose to go to that particular facility?

3. If the police were notified, how did this take place? How were they contacted, how fast did they react, what did they do for you? Were they sympathetic? Was the officer male or female?

4. How would you rate the quality of attention you received from the police?

   a. _____ excellent

   b. _____ Good

   c. _____ Fair

   d. _____ Poor

5. If fair or poor, how could it have been made better? If good or excellent, what made it so good?

6. Was an arrest made? How did making the identification of the suspect make you feel?

7. What were the reactions of your family and friends to the assault?

8. Who among your family and friends was particularly helpful? How were they helpful?

9. Who among your family and friends was the least helpful? How were they not helpful?

10. If an arrest was made, how far was the prosecution carried? Has the case been settled yet? What was the outcome?

11. If you were to be assaulted again, what would you do differently in terms of reporting to the police, or seeking prosecution?

12. What services did you receive from the rape crisis program?

13. How would you rate the quality of the services of the rape crisis program? Circle one letter below.

a. excellent

b. good

c. fair

d. poor

14. If fair or poor, how could they have been made better? If good or excellent, what made them so good?

15. Did you receive any other services from any other agency as a result of the assault (such as mental health or legal services)? What were they? Were they helpful?

16. What kinds of problems did you have as a result of the assault that weren't met through one of the agencies we have asked about?

17. Were your needs to deal with these problems met in some other way, or have they been unmet?

18. Could anything have been done for you that wasn't done to make getting over this experience any easier?

19. How did you learn about the group program for rape victims?

20. Please indicate how many times you attended a group session. Circle one:

a. 1-4 meetings

b. 5-10 meetings

c. 10-16 meetings

21. How would you rate the helpfulness of the group meeting? Circle one:

a. excellent

b. good

c. fair

d. poor

22. If fair or poor, how could the group meetings have been made better? If good or excellent, what made them so good?

23. Would you recommend the services of the rape crisis center to a friend or family member, if they should be assaulted?

a. yes, definitely

b. possibly

c. never

APPENDIX D

SERVICES TO RAPE VICTIMS IN FLORIDA, 1984:
A NEEDS ASSESSMENT STUDY

Florida has the dubious distinction of being the state with the third highest rape index in the nation (in 1982, with 53.6 rapes per 100,000 of the population), second only to Alaska (85.4) and Nevada (61.5). Many of Florida's cities and counties, furthermore, have rape indices (standardized for population size) which far exceed the national average of 33.6. Whether this is due to Florida's rapid growth and attendant social problems, the annual influx of tourists and "snow birds," or a responsiveness to victims which fosters higher reporting rates in some parts of the state is unknown. This report, based on a ten-month study funded by Florida's Department of Health and Rehabilitative Services (Health Program Office), provides an overview of the problem of rape in Florida, examines the experiences of rape victims in Florida, describes services offered by the major providers in our state (a "service system" which includes law enforcement--both police and sheriff, hospitals, specialist rape service programs, State Attorney offices, and other providers), and identifies ten major findings and 64 recommendations relative to services to rape victims in the State.

Rape in Florida. Based on available data, 93 percent of sexual battery victims in Florida are female. While the number of male victims has increased, most of this increase (outside of jails and prisons) involves male children. The number of child victims of both sexes is high and experts around the state believe the incidence as well as the reporting rate of child sexual abuse is increasing. The predominant assailant for all kinds of sexual assault is male. Contrary to popular stereotypes, stranger rape is far less frequent than is typically assumed. For all cases of sexual assault, about 50 percent are committed by someone known to the victim and in cases with child victims, the percentage is 80 percent. This point is emphasized because research on rape shows that victims assaulted by someone they know (friends, acquaintances, relatives, etc.) suffer more psychological problems in regards to reporting and prosecuting and relative to loss of feelings of safety and trust. Recovery from the "rape trauma syndrome" is particularly difficult for children assaulted by someone they know due to guilt feelings associated with arrest, prosecution, and possible imprisonment of a father, uncle, neighbor, someone from church, and so forth. The increase in child sexual abuse cases and the complexities of processing such cases and meeting the child victim's needs call for additional research and prompt action by Florida officials at all levels of government (see recommendations).

Available data suggest that the majority of rape victims in Florida are white (about 64 percent) and that between 73 and 84 percent of all victims are aged twenty-five and under. Data from Broward and Dade Counties show a high percentage of children as sexual assault victims, with 15.1 percent of victims aged 11 or under (in 1982) in Broward and 22.5 percent aged 12 or under (in 1982) in Dade County. Victims of sexual battery in Florida appear, therefore, to be those who are most vulnerable: the young and females. Young females, naturally, are the greatest "at risk" category. Most rapes occur, furthermore, within (rather than across) racial or ethnic categories.

Based on the FBI's Uniform Crime Report Program's definition of forcible rape (which, we note in the report, is much narrower than Florida's Sexual Battery Statute), there were 5,170 rapes in Florida in 1983, giving the State a rape index of 48.81. Florida's [illegible] with the highest rape indices (rapes per 100,000 population) in 1983 were, in descending order, DeSoto (97.11), St. Lucie (76.02), Duval (74.09), Leon (69.20), Escambia (66.36), Orange (65.60), Alachua (64.65), Hillsborough (63.33), Polk, (59.96), and Monroe (58.55). Cities with the highest rates were: Daytona Beach (112.60), Lake Worth (110.33), Orlando (105.84), Tampa (104.98), West Palm Beach (98.58), Miami (94.77), Riviera Beach (90.31), Sarasota (89.71), Deerfield Beach (81.37), and Tallahassee (77.66). Six counties reported no rapes in 1983 (Calhoun, Glades, Gulf, Lafayette, Suwanee, and Union) and three counties reported only one (Washington, Holmes, and Madison). Interestingly, with one exception, all counties with one or no rapes reported have total populations of 15,000 or less and none is a major resort or tourist area.

It should be emphasized that a high rape index is not necessarily a negative sign regarding a city or county. The index reflects only those rapes reported to law enforcement agencies which, research indicates, may be between one-tenth to one-half of the rapes which occur. Localities which show greater responsiveness and support to victims of sexual assault may therefore have higher reporting and higher apparent rates. Additionally, the population on which the indices are based does not include tourists, snowbirds, and transients (including certain students at universities and colleges), thus figures for such counties as Leon and Alachua may imply a greater probability of rape than actually exists. The same holds true for tourist meccas such as Daytona Beach, Orlando, West Palm Beach, and Miami (among others).

Arrest figures for Florida show it to be similar to the nation. The crude arrest "rate" for the USA in 1982 was about 35 percent and for Florida in 1983, it was 32 percent. This indicates that arrests are made in roughly one-third of reported rape cases in Florida. As with the rape index, arrest rates vary dramatically across the state. Among counties with 100,000 or more population, those with the highest arrest rates are: Sarasota (88.7), Marion (71.2), Okaloosa (59.0), Alachua (54.0), and Bay (51.5). Interestingly, four of the five counties (excepting Bay) have active rape service programs and an active service network on behalf of victims. Arrest rates for Florida's most populous counties (i.e., Dade, Broward, Pinellas, Hillsborough, Palm Beach, Duval, and Orange) where, admittedly, identification of assailants is far more difficult than in sparsely populated areas, have an average arrest rate of 31.5, with Dade highest (38.4) and Pinellas (26.0) lowest. Figures on prosecution of alleged rapists in Florida are basically unavailable.

A recent study by Florida's Department of Law Enforcement of forcible rape in Leon County in 1982 and 1983 provides some indication of prosecution and conviction patterns. Among 170 cases of "forcible rape" reported in the two years of the study, arrests were made in only 55 cases (or about 32 percent). Of the 52 cases which were resolved at the time of the study, only 22 were closed with guilty of sexual battery convictions (three pled no contest and 19 were found guilty) and only 18 of these actually received prison terms. This means that 12.9 percent of 170 assailants were found guilty of some degree of sexual battery and 10.6 percent went to prison for it. Additionally, among the remaining arrestees, 19 cases were not filed or Nol Prossed (basically, dismissed early in the case's tenure) and 8 were plea bargained to lesser crimes (e.g., battery or lewd and lascivious behavior). Based on these figures, the odds of a rapist being imprisoned in Florida appear fairly minimal--about one in eight to one in ten.

Little is known to date regarding the long-term effects or implications of Florida's Sentencing Guidelines on the fate of convicted sexual battery offenders in the state. One study shows that judges deviate from the Guidelines in Sexual Offense cases more so than any other type of felony involving Crimes Against Persons. They are about as likely, however, to aggravate (increase) as to mitigate (decrease) the suggested sentence. In light of the widely held view that the Guidelines give first offenders in Florida "one free rape," one recommendation of this study is that research on the application of the Sentencing Guidelines be conducted to determine their effects on both victims and offenders and on the reduction of sexual battery crimes in our State.

Florida neither collects nor maintains data on its own Sexual Battery Statute and systematic evidence on the extent of sexual battery is lacking. Related data which are collected (as directed by Florida Statute) are gathered in line with the FBI's Uniform Crime Report Program which defines rape as something which, by definition, a male does to a female and which involves penetration of the female vagina by the male penis. All other crimes of a sexual nature are excluded from the FBI's Forcible Rape category. Florida's Sexual Battery Statute includes as sexual battery such crimes as sodomy, fellatio, rape with fingers or foreign objects, and so forth. Florida is recognized as having one of the most "comprehensive" or advanced sexual assault laws in the nation and the absence of systematic data to gauge the extent of the crime as reflected in this Statute is inexcusable. We recommend that steps be taken to collect data from the 341 law enforcement agencies in the state on the incidence of sexual battery reports and arrests. Additionally, we urge that judicial circuit and statewide data on prosecution be collected relative to this statute. In particular, it is important to know the number (and percent) of cases of sexual battery in which charges are filed, the number and types of charges filed, and the final disposition of cases originally filed with sexual battery charges.

Florida's financial support for victims of rape consists of offender fines which are used to reimburse medical and law enforcement personnel for conducting the sexual assault examination protocol/rape kit for evidence collection from the victim's body. Since the Bureau of Crimes Compensation began reimbursing for the rape kit exam in July of 1982, $800,000 has been expended for sexual assault victims (through June of 1984). Data are not maintained on sexual assault victims who have requested compensation for medical expenses or lost wages incurred

as a result of the rape but BCC staff estimate requests for compensation from rape victims under this program are minimal. Additional funds expended by the State on rape victim services are federal monies earmarked for research and demonstration projects which are dispensed and monitored by the Department of Health and Rehabilitative Services (some of which funded the present research). Most funding for rape victim services in Florida is locally provided by a variety of sources including United Way, county and city governments, foundations, and private donations. (Chapter 5 of the report describes funding sources of Florida's rape service programs.)

Synopsis of the study and final report. The research for the study took place between September 1983 and June 1984. Data were collected by means of face-to-face interviews with service providers across the state. Areas were visited personally because past experience reveals that mailed questionnaires are unsuccessful in gaining needed information. The targeted service providers in each locality were as follows: staff of rape service programs (typically called rape crisis centers, hotlines, etc.), personnel in police and sheriff departments, hospital/medical staff (who perform the sexual assault examination), state attorney staff, and other persons identified by the locality as involved in rape victim services (e.g., mental health centers, citizen action groups, Child Protection Teams, and so forth). In all, over 200 people in 130 organizations were interviewed including 25 rape service programs, 42 law enforcement agencies, 24 hospitals, and 21 State Attorney Offices. Interviews focused on services to victims provided by the organization, efforts by the organization to prevent rape (including target groups and prevention messages), and relations with other service providers in the locality. Figures on the incidence of rape were requested and, if not available, estimates were accepted. Estimates of time spent and number of contacts with a "typical victim" were also requested. Additional data for the report were collected from the Florida Department of Law Enforcement, the State Court Administrator's Office, and the Bureau of Crimes Compensation. These were analyzed to provide an overview of sexual assault crimes in the State of Florida and results of this analysis are presented in Chapter 1 of the report. Chapter 2 overviews the study's research methodology and explains that eleven victims were interviewed in addition to the 130 organizations. Chapters 3 through 7 present findings as follows: law enforcement, hospitals, rape service programs, state attorneys, and the local service network. Within each chapter, an overview of services to victims by that type of organization precedes a section on Unresolved Issues which confront that particular service arena. Each chapter ends with a description of between fifteen and twenty Innovations which reflect particularly effective and creative ways of serving victims. Innovations are identified by agency and city/county so readers interested in adopting the practice can contact the exemplary program for suggestions and advice. Chapter 8 presents results from research on victims regarding the quality of services received in Florida. Finally, Chapter 9 presents the study's major findings and recommendations for action and research. A brief overview of Chapters 3 through 8 follows.

Chapter 3 reviews the role of law enforcement in serving rape victims. Law enforcement officers are the first representatives of the "service system" to meet with rape victims after the rape has been reported and, as such, are critical to either facilitating victims' recovery from the trauma of the rape or retarding it. It is crucial that sensitive, caring individuals be selected to work with rape victims, either as uniformed officers or investigators. Although law

enforcement officers have the responsibility to apprehend assailants, they are also charged with ensuring victims' safety and emotional and physical well-being. Uniformed officers usually transport victims to a hospital where medical treatment can be provided if necessary and where the rape kit examination can be performed. Investigators take victims' official statements and are usually assigned to the case until it is closed, either through arrest of a suspect or clearance by other means. We have recommended that all law enforcement officers who may encounter rape victims receive training both in sensitivity and in agency policies and procedures concerning the proper handling of such cases.

Chapter 4 examines the role of hospitals and other medical facilities in serving the needs of rape victims. In most parts of the State, rape victims are taken to a hospital emergency department for medical treatment and the rape kit examination. Extensive medical treatment is required for only a small percentage of rape victims; however, treatment for venereal disease and a discussion of pregnancy prophilaxis are standard in many hospitals. The rape kit examination is not medical treatment; it is a process of evidence collection for use in making a case against an alleged assailant. It involves a thorough examination of a victim's body for evidence of sexual contact and clues which might lead to the identification and arrest of a particular assailant. The rape kit is usually performed by a physician, since it involves an internal pelvic examination. A number of problems are identified which relate to physician involvement. These include: excessive waiting time for victims to be seen by physicians, physician reluctance to perform evidence collection which may require them to testify in court, and charges in excess of those reimbursed by the Bureau of Crimes Compensation. Increasingly, the necessity of physician involvement is being questioned and numerous alternatives are being adopted throughout the state. The most promising of these alternatives involves specially trained nurse examiners or nurse practitioners taking complete responsibility for performing the rape kit, including the pelvic examination. A model program is in Tampa, where nurse examiners perform the rape kit as well as provide limited medical treatment to rape victims. This program results in consistent, high quality services to victims and evidence which stands up well in court. The program is strongly supported by law enforcement, State Attorney Office, and medical providers as well as other individuals and agencies in the service system and by rape victims themselves.

Chapter 5 describes Florida's 25 rape service programs. Rape service programs are defined as meeting three or more of the following criteria: (1) are identified by their staff and available documents as working specifically with rape victims; (2) have staff whose primary or sole responsibility involves working with rape victims; (3) have specific services for rape victims which are different from other services offered by a parent agency; and (4) have a separate budget or budget line from other components of a parent agency.

Most rape service programs in Florida specialize in crisis intervention, provided either over the telephone or face-to-face. Many programs send a staff member or volunteer to the hospital to provide crisis services to rape victims while they are receiving the rape kit examination and being questioned by law enforcement. Rape service programs also work with victims who have never reported the rape to law enforcement; estimates indicate that as many as half of the clients of rape service programs do not report the rape and may not request

services for months or even years after the rape has occurred. Most rape service programs provide advocacy services to rape victims, which consist primarily of accompanying victims to court or other official appearances and acting as their advocate with other agencies in the service system. The majority of programs also offer ongoing counseling to a limited extent. The dearth of qualified counselors as well as the lack of funds to support them was noted frequently as a critical problem throughout the state. Accordingly, we recommend that specially trained counselors to work with rape victims, particularly child victims, be made available throughout the state.

Nearly all rape service programs are seriously underfunded. Most exist due only to the efforts of volunteers who donate countless hours to the programs and to the victims whom they serve. The average (mean) number of paid staff in rape service programs throughout the state is 3 and the average number of volunteers is 17. More than half of the programs do not even have an identifiable budget. Due to this serious underfunding in the face of such a major social problem, rape service programs have adopted many survival tactics. Most rely on volunteers to provide at least some of the program's services. Nearly all programs are affiliated with a parent agency which provides them with some administrative and financial support. Rape service programs are found associated with hospitals, mental health clinics, county social services, spouse abuse shelters, and so forth--whatever agency will provide them a "home" and support. Many programs focus on crisis intervention to the exclusion of other services due to their obligation to serve the neediest group first. With the chronic underfunding and minimal community support, it is amazing that rape service programs exist at all and that they manage to function on the high level they do; this is a tribute to the dedication of the staff and volunteers of these programs. We recommend that communities assume more responsibility for providing a broad range of services to rape victims to the extent of providing greater financial support to existing programs and initiating new programs in areas currently lacking such services.

Chapter 6 concerns the State Attorney's role in serving rape victims. Only a minority of rape cases reported to law enforcement result in the arrest of a suspect and in even fewer cases are charges filed against the alleged assailant. Thus, the state attorney is involved with only a small proportion of rape victims. The State Attorney's role is to prosecute the rape as a crime against the state, with the victim as the primary witness to the crime. Rape victims frequently testify in court as to how the crime occurred, but often feel that their wishes and involvement are relatively immaterial to the case. Rape victims frequently complain about a lack of knowledge of and involvement in their cases. We recommend that prosecutors contact victims regularly to keep them informed about their cases, that one attorney follow a case until its conclusion, and that where possible specialized sex crimes prosecution units (or prosecutors) be established within State Attorneys' Offices.

Chapter 7 examines the interactions of all providers and others (e.g., mental health clinics, Child Protection Teams) as a service system designed to work with rape victims. We found victims to be best served in localities where agencies meet together regularly to discuss general issues of importance to serving rape victims.

Chapter 8 describes the reactions of rape victims to the services they received from the "service system." In general, they were most positive about the helpfulness of rape service programs and felt that these services assisted their recovery from the trauma of the rape. Victims were not as positive about law enforcement agencies and State Attorney Offices, frequently perceiving a "blame the victim" attitude on the part of their personnel.

Major Findings. The study's ten major findings are as follows. (1) Florida has 25 outstanding rape service programs serving survivors of rape across our state. Florida's rape service programs vary in organization and format and embody a range of approaches to specialized services to victims of rape. Some are staffed solely by paid, professional personnel whereas others are run exclusively by unpaid volunteers (who, incidentally, may be professionals who volunteer their time and energies). All twenty-five programs have emerged over the past decade and represent an impressive range of approaches to serving victims of sexual assault.

(2) Understanding and treatment of rape victims in Florida has improved dramatically in the past decade. [illegible]ding of the problem of rape and sensitive treatment of sexual assault victims in non-specialist agencies and organizations in Florida is much better than it was a decade ago. Particularly in urban areas and in localities with active rape service programs, training regarding technical skills and attitude is provided and emphasized for all personnel who work with rape victims. Many law enforcement officers, in particular, remarked to us on improvements in their organizations over the past few years. It should be noted that progress in these areas is uneven and some localities do a much better job than others. It is nevertheless true that some police and sheriff departments, hospitals, and State Attorney's Offices are serving Florida's rape victims in an exemplary manner both technically and relative to sensitivity in interpersonal relations. If such prototype approaches were adopted on a wider scale, treatment of rape victims in Florida would improve.

(3) Thirty-one Florida counties lack specialized rape victim services. Whereas thirty-six of our counties are served by specialist rape service programs, thirty-one are not. Rural counties are particularly likely to be unserved. If we were able to assume that sexual assault occurs only in urban areas, this might be acceptable. As data reviewed on Florida's counties and cities in Chapter 1 reveals, however, rural and less urban areas have sexual assault just as urban areas do and the needs of victims are basically the same regardless of demographic, social, and cultural particularities of the area. The absence of services in many areas of the state is addressed in the recommendations sections of Chapter 9 (see below).

(4) Closely linked service networks provide high quality services to rape victims. When service providers in a locality are closely associated through frequent meetings and other face-to-face contacts, victims in that area are typically well-served (see Chapter 7). Face-to-face contacts allow people to become acquainted, learn to trust each other, and to be educated regarding the crime of rape and its trauma for those who experience it as victims. When people in different segments of the network communicate directly regarding their jobs and roles, all participants are enlightened regarding the experiences of and demands on victims as they "progress through the system." Although numerous methods are used in Florida to establish and maintain well-linked service

networks, regularly scheduled meetings on a periodic basis (e.g., once a month or once every six weeks) of representatives of rape service programs, police, sheriff, hospital, and State Attorney with an agenda of improving services to rape victims appear to be a consistently effective procedure.

(5) More money is needed for rape victim services and rape prevention efforts. Financial resources from the State for rape victim services in Florida consist almost solely of fines collected from offenders and dispensed on behalf of victims through the Bureau of Crimes Compensation. As discussed in Chapter 1, these funds are used primarily to pay hospitals and physicians for conducting the sexual assault examination protocol (rape kit) at $150 (maximum) per victim-incident. Between July 1982 (when this program went into effect) and 30 June 1984, a total of $797,200 has been dispensed to medical facilities or personnel by Crimes Compensation for rape kit exams ($150 each for 5,314 exams). The nearly $800,000 provided through Crimes Compensation is, it is recalled, primarily for law enforcement purposes since physical evidence of rape is primarily found on the victim's person.

Staff of rape service programs emphasized the difficulties of raising funds at the local level for rape victim services. "Spouse abuse" programs and problems, in contrast to rape, are popular and are generally supported by churches, civic clubs, and individuals in addition to state funds received through the Marriage License Fee Trust Fund. Rape, however, is a stigmatized topic about which people feel uncomfortable and one which they are much less likely to understand and support. If state funding for program establishment is not forthcoming, it is difficult to envision how the 31 presently unserved counties will acquire specialized services for rape victims. Programs which are currently underfunded will also continue to have a precarious existence. In short, if Florida is to shed its dubious distinction as a national leader relative to forcible rape, more resources --from the state and its counties and municipalities--will have to be secured.

(6) Little emphasis is given statewide to the prevention of rape. Many people in Florida, indeed most, have little understanding of the causes of rape and even less of a concept regarding how to prevent it. This includes many who work directly with rape victims although service providers are more aware of the problem and its root causes than is the general public. We conclude, therefore, that too little emphasis is placed on the prevention of rape in Florida. Prevention messages and themes which are in place, furthermore, focus on avoidance of rape rather than on conditions, practices, and attitudes which foster it. Avoidance may frighten potential victims while basically leaving the problem intact. In addition, those who lecture or provide information on rape often have potential victims as their sole or primary target group. This emphasizes only one end of the sequence and reinforces the tendency to view rape victims as having caused their rape. Finally, prevention efforts by those other than rape service programs in Florida are few and far between and generally reactive rather than proactive. Most law enforcement agencies, hospitals, and State Attorney Offices make relatively few presentations on rape and rape prevention and, when they do, they generally focus on potential victims rather than perpetrators of the crime. The involvement of adult males in prevention outreach is particularly important. Thoughtful prevention messages from respected males to other males have great credibility and impact.

In understanding the root causes of rape, the issue of who rapes must be addressed. Most rape victims are female; most rapists are male. To address the problem directly, males--particularly young males--need to be talked to, socialized, and instructed regarding the unacceptability of rape in our society. Since the young are often easier to reach and teach than older people, school children are an important target group for prevention efforts. Additionally, a culture which teaches little boys it is "sissy" to cry or that tender feelings and actions towards females are unmanly must be changed. In short, all societal structures and practices which devalue females and which foster male machismo and/or physical dominance and force in male-female relations contribute to an assumption that males are expected to rape. This assumption needs to be confronted and challenged in Florida (and society as a whole).

(7) The myth that rape victims cause their sexual assault is still pervasive. The myth that victims of sexual assault are somehow responsible for the crime to which they were subjected is pervasive in Florida not only among the general public but many service providers as well. This myth is often employed in descriptions of rape involving child incest and all ages of female victims; it is less frequently employed regarding male victims but the relatively small proportion of rape victims who are male may account for this. Few would suggest a family caused its home to be burgled. Even if a window were left unlocked, the entry and theft would be regarded as a crime and family members would not be viewed suspiciously or thought to have precipitated the crime. Victims of sexual battery in Florida are, however, all too frequently viewed in this way. College-educated, otherwise sophisticated people--male and female--make comments in good faith that girls who are "out at 2 a.m.," who wear short shorts, or who walk alone after dark are "asking for it." When a male walks alone after dark, is he "asking for it?" Or is he simply going from one place to another after dark? If a male wears skimpy clothing, is he asking to be raped? Of course not. He does not want or expect to be raped; he wants to go and do whatever he wants to go and do--and not be afraid, literally, for his life. Females--and males--of all ages want no less. To place the responsibility of rape on victims is a distortion of reality. If offenders did not force themselves on unwilling victims, there would be no rape victims. If parents who sexually abuse their children did not initiate the assault, there would be no incest. To suggest that females who engage in certain behaviors cause themselves to be raped or that children who are sexually [illegible] adults into assaulting them is to treat offenders as if they have no responsibility for their actions and suggests that rape is an automatic response on the part of certain people who lack will or judgment of their own. Erroneous views of rape victims abound in Florida and must be combatted by those who understand this crime and wish to abolish it. It will not be easy; an entire society is geared to viewing rape victims as at fault. Florida can become a leader, however, in articulating a more realistic and accurate perspective. Victims do not, in almost all cases, cause their own rape. It is time therefore to direct more attention to those who rape and to identify ways of reeducating potential offenders to disavow rape and assume greater responsibility regarding unwanted and non-mutual sex of any form. It is past time, furthermore, to eliminate all stereotypes, practices, and structures in society which contribute to a subordinate status for women and which foster assumptions that some people have a right to force sexual activity on others.

Major findings 8, 9, and 10 were reviewed earlier in this summary and are as follows: (8) Florida collects too little data on sexual assault; (3) females remain the primary victims of sexual battery in Florida; and (10) the number of child victims of sexual battery is increasing.

Recommendations. In light of the study's findings, 64 recommendations on the topic of services to victims of sexual assault are offered for the State of Florida for the coming decade. Some recommendations are general, applying more to the statewide or supralocal level whereas others apply more to local areas. Recommendations which apply to both levels are included in the General Category. Recommendations in the Specific Category are organized according to Chapters 3 through 7 with particular points for law enforcement, hospitals, rape service programs, State Attorneys' Offices, and service networks. For this summary, we present complete recommendations of a general nature but only abbreviated versions of those for particular service sectors.

General recommendations. Fifteen recommendations of a more general nature are as follows. (1) Specialized services to victims of sexual assault should be made available in every part of the State. (2) State-level funding should be provided for rape victim services in Florida. Support is essential in two areas: technical assistance to unserved or underserved areas and support for on-going specialized rape service programs. (3) Greater attention to preventing rape/sexual assault should be given by all levels of government, state, county, and municipal. (4) Local, circuit, and statewide data need to be routinely collected and reported relative to Florida's Sexual Battery Statute. (5) Research on child sexual abuse should be done to identify the kinds of services children are receiving and need and the programs which are most successful in assisting child victims and their families. (6) We recommend the establishment of a statewide network of rape service programs in Florida, to foster communication and sharing among programs and interested citizens across the state. (7) Research on the prevention of rape in Florida is recommended with particular attention to the success of differing methods, approaches, and materials aimed at specific target groups including potential assailants as well as victims.

(8) We recommend that more long-term treatment services for rape victims be made available in Florida. (9) We recommend that more publicity and better dissemination of information be provided to survivors of rape/sexual assault regarding the availability of reimbursement for medical expenses and lost wages resulting from the assault. (10) We recommend that victims receive more assistance in applying for funds for medical expenses and lost wages from the Bureau of Crimes Compensation. (11) We recommend that technical assistance be provided to parts of the state which presently lack rape service programs and/or particular kinds of services essential to rape victims. Funds could be used most urgently to pay for training of nurse examiners regarding the rape kit exam and training for specialized counselors and advocates to work with victims on both short and long-term bases. (12) Research is needed on the effects of Florida's Sentencing Guidelines on both a judicial circuit and statewide basis. (13) We recommend that rape victims be asked by providers in all types of agencies their assessment of services received. (14) We recommend a change in Florida's Sexual Battery Statute to disallow any admission of the victim's sexual history as evidence in court. (15) We recommend that mental health centers in Florida take steps to provide crisis and long-term counseling to victims of sexual battery in Florida.

Specific recommendations. Recommendations 16 through 27 refer explicitly to law enforcement and deal with the following topics: (16) training and standards, (17) written protocol for sexual battery cases, (18) screening of officers, (19) specialized units or investigators, (20) written policy for unfounding, (21) no routine use of lie detector tests with victims, (22) keeping the victim informed, (23) minimizing opportunities for victim embarrassment, (24) more public education prevention, (25) use of photo or video-tape line-ups, (26) acceptance of third party reports of rape, and (27) honesty regarding the rape kit exam.

Recommendations 28 through 36 refer to the hospital where the rape kit examination is typically performed. These are as follows: (28) separate quarters for rape kit exam, (29) nurse examiners should perform rape kit exam, (30) specialized training should be provided for nurse examiners/practitioners, (31) the rape kit exam should be standardized for the entire state, (32) there should be no routine plucking of victims' pubic hairs, (33) treatment for VD and pregnancy should be offered to sexual battery victims, (34) rape victims should not be held liable for any costs or charges associated with the rape kit exam, (35) free follow-up medical exams for victims, and (36) the State should consider contracting for rape kit and follow-up exams at local levels.

Recommendations 37 through 48 refer to rape service programs and are as follows: (37) specialized services in every county, (38) prevention messages to general public, (39) routine alerts by hospital and law enforcement to rape service programs, (40) staff from RSP should meet victims at hospital, (41) RSP staff should provide literature/brochures to victims, (42) crisis and long-term counseling should be provided, (43) local government funding for rape services must increase, (44) specialized services for child victims need to be increased, (45) more practical services for victims are needed, (46) RSP staff should train personnel in other agencies, (47) greater efforts to reach minority victims are needed, and (48) speakers' bureaus to speak on prevention should be developed.

State Attorney recommendations include 49 to 58 and are as follows: (49) special prosecutors and/or units should handle all sexual battery cases, (50) SAOs should file on more cases, (51) a single prosecutor should remain with a case from beginning to end, (52) victims should be invited to pre-filing interview, (53) regular contact should be maintained with victims, (54) written guidelines for sexual battery cases should be developed, (55) specialized training should be provided for assistant State Attorneys relative to sexual battery, (56) Sentencing Guidelines and plea bargaining patterns should be monitored, (57) SAOs should report regularly to rape service programs, and (58) video-tapes should be used in child victim cases. Recommendations for the service network include: (59) establishment of a permanent, working task force, (60) appointment of short-term, citizens' action groups to study and recommend on rape victim services, (61) conduct more community education on prevention, (62) expand local support base for rape victim services, (63) hold regular, bi-annual in-service training for staff in all organizations which serve rape victims, and (64) conduct local studies of rape incidents, arrests, and prosecution.

APPENDIX E : FY 84/85 BUDGET

Subobject	Amount	Account Name
1010	192,870	Salary
1025	21,081	Retirement
1030	13,593	F.I.C.A.
1035	22,145	Group Insurance
1040	3,426	Workmans Compensation
3085	720	Material for Construction
3090	450	Miscellaneous
3095	2,000	Office Supplies
3097	250	Misc. Office Equipment
3100	300	Printing
3101	2,400	External Printing
3110	400	Medicine and Drugs
3115	3,000	Medical and Surgical Supplies
3125	374	Video Supplies
3265	89,820	Medical Expenses
3291	840	Rental: copier
3295	4,500	Psychiatric/Psy. Services
3350	1,075	Travel
3380	4,790	Telephones
3390	150	Dues/Memberships
3395	1,909	Self-Insurance
3396	350	Purchased Insurance
3400	125	Subscriptions
3440	2,200	Building Maintenance

TOTAL: 372,408

APPENDIX F: Relaxation Exercises*

The relaxation exercises which follow are best performed in a quiet room where you can lie down and not be disturbed for at least 15 minutes. If you want, and this is recommended, read the instructions for each exercise into a tape recorder. This will allow you to play back the same instructions each time. Additionally, you will be able to devote more of your concentration to relaxing rather than to instructing yourself how to relax. One other suggestion is that you do not drive any motor vehicle for at least 30 minutes after completion of the exercise.

You will be given instructions for several exercises. Each ensuing exercise will include the skill from the preceding one. Therefore, you are responsible for practicing these techniques so that you can become proficient at them. From the beginning, these exercises will increase your awareness of both your mind and body, improve your concentration abilities, help you to perform in stressful situations, and relax you in such a manner as to enable you to achieve your optimal stress level for an event.

* Adapted from course material- Stress Management Dec. 1983

BREATH AWARENESS:

Lie down on your back, either on a carpet or a bed. Make sure you are comfortable. Uncross your legs and keep your arms at your side. Take off your shoes and loosen your clothing. Make yourself as comfortable as possible as you prepare yourself to enter a state of relaxation.

Start to breathe deeply, filling your lungs with air. Inhale slowly and exhale slowly. Continue breathing in this manner. If you begin to feel light-headed, that is all right. It means you are starting to relax. Now, open your mouth and inhale through your mouth. Push your stomach out as you inhale and get the air all the way down. Now exhale slowly. Keep breathing deeply and concentrate on the air going in and out of your body. (Pause 5 seconds.)

Keep breathing deeply, and with your eyes still closed, roll your eyeballs up into the top of your head. Try to look at the back of your head. Hold them up there for five breaths, keeping your eyelids closed. Then, as you exhale the fifth breath, let your eyeballs fall into their normal position. You will now feel very relaxed.

Continue breathing, inhale deeply and exhale completely. Now, each time you breathe out, imagine all the tension flowing out of your body. With each breath, you become more and more relaxed. Your arms and your legs begin to feel heavy and warm as you relax even more. With each breath, the tension flows from your body and you are achieving deeper relaxation.

As you relax, notice the tingling sensation that comes over your body. Enjoy the good feeling of relaxing and letting go. As you relax more, your body gets heavier and warmer. Enjoy this feeling, secure in the knowledge that you have brought it about. You are in control of your body!! Tell yourself, "I am calm and in control." Repeat that to yourself three times. (Pause 5 seconds.)

Now tell yourself, "I am a confident and capable person. I am a confident and capable person." Repeat this phrase to yourself five times. (Pause 10 seconds.)

Now choose a situation from your past which you handled perfectly. Everything went just as you expected. Your performance was perfect. On that day, you were the best. Relive that time over in your mind. Enjoy all the sensations that were associated with it: the sights, sounds, smells, feelings, physical touching, everything. Just enjoy it thoroughly. You were the best, and you will be the best again. Every time that situation or one similar to it arises in your life, you will perform perfectly. Remain secure in the knowledge that you can control your actions, and behave in the best manner possible whenever it is necessary.

Begin to concentrate on your breathing again. You will begin to bring yourself out of the state of deep relaxation. Count forward from one to five, and after you say each number to yourself, repeat "I am relaxed and refreshed and full of energy." When you reach five, begin to wiggle your fingers and your toes. Open your eyes whenever you are ready, stretch out slowly, and enjoy the good feelings you have.

END.

MUSCLE AWARENESS:

For this exercise, follow the instructions on the first page of the instructions for the breath awareness technique. Then continue on with the following instructions, making sure you pause at least five seconds between each muscle group.

Concentrate on relaxing the muscles in your feet, legs, and thighs. Imagine them going loose and limp. Feel them going loose and limp. Feel the tingle in them and the warmth as they relax.

Relax the muscles in your head and neck. Feel them just dropping as a wave of relaxation comes over them. Enjoy the feeling of warmth as all the tension flows from your head and neck.

Now relax the muscles in your shoulders. Imagine them sinking into the bed as they become heavy and warm. Feel your arms also becoming heavy.

Relax your arms. They are becoming heavy and warm. Enjoy the feeling of relaxation as the tension begins to flow from your body. As you relax deeper, your fingers will tingle and may become numb. That is quite all right. It means you are achieving a state of deep relaxation.

Now concentrate on relaxing the muscles in your chest. As your chest relaxes, your breathing becomes much easier. Also, your stomach begins to relax, so you must allow it to do so. Let all the muscles in your chest and stomach relax. Concentrate on the good feeling as the tension leaves your body.

Picture the muscles in your back relaxing. First, relax your upper back. As the tension starts to decrease, begin to relax your lower back. Feel the waves of relaxation as they flow over your back. Feel yourself sinking deeper into the mattress. As you sink deeper, you relax more and more.

Now concentrate on relaxing the muscles in your buttocks. Let them go loose and limp. As they do, relax the muscles in your thighs, legs, and feet one more time. Just lie there for about a minute. Enjoy the feeling of relaxation that has come over your entire body. Think of nothing else.

Now that you are very relaxed, focus your concentration on a spot directly behind your navel. Imagine this spot as you think it should look. Center yourself on this spot for the next minute.

Now that you are centered, let your imagination go. Focus your concentration on any situation that in the past has given you trouble. However, this time, imagine the situation with all its pressures and a different outcome. This time, picture yourself handling the situation as perfectly as possible. Keep all your thoughts geared toward success. Believe in yourself and imagine yourself performing automatically and flawlessly.

Enjoy all the sensations of your performance in this situation. Savor them as long as you like. Bring all your senses into play so you can be completely aware of what you are mentally rehearsing. Enjoy it, and remember that you can make that situation, and any other situation, happen exactly the way you imagined it.

At your own pace now, bring yourself out of the state of deep relaxation. Start to bring your awareness levels up, begin to wiggle your fingers and toes. Take some deep breaths. Whenever you are ready, sit up, tell yourself you are relaxed and refreshed and full of energy. Stretch out, and be ready to face the rest of the day with a positive attitude.

REMEMBER! You are in control. You alone are responsible for what happens in your life. Go out and make each day a great one. Make each venture a successful one. Enjoy yourself, and be at peace with yourself and the world around you.

While you are involved in any of the relaxation exercises, your conscious mind is becoming quiet while your subconscious mind is awakening. This is what you want to do. The more you can awaken your subconscious, the more things you will be able to accomplish. The subconscious is like a computer. It stores everything put into it and it knows how to get the best out of what is in there. The only way for you to do this is to free your subconscious by relaxing your conscious mind.

When you are relaxed, program your subconscious mind. If you have a speech to give or a test to take, rehearse that in your relaxed state. Always imagine a successful outcome. Then, congratulate yourself for successfully completing the task. If you want to improve your memory or your self-confidence, just give yourself positive affirmations "My memory is excellent, or I am very confident." Whatever you say to yourself in the relaxed state will be remembered. With more practice, you will get better at it. Soon, everything will be happening as if automatically, without conscious intervention on your part. It is at this time that you have achieved a great amount of self-control.